IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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September 2, 2008

Joseph Messmer
Mercy Medical Center
1512 Twelfth Avenue Road
Nampa, Idaho 83686

Provider #130013

Dear Mr. Messmer:

On **July 10, 2008**, a Complaint Survey was conducted at Mercy Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003540

Allegation #1: Emergency department (ED) patients had experienced extensive long waits to be seen by the triage nurse.

Findings: An unannounced visit was made to the hospital on 7/8/08. Thirty-Two clinical records were reviewed of ED patients. Additionally, staff were interviewed and hospital policies were reviewed.

The hospital's "Triage Policy", effective as of 2/08, stated "A quick triage will be completed on all patients." The hospital's "Plan for Provision of Patient Care", effective as of 3/06, stated "Patients are triaged by an RN assessment and should be timely and brief....The goal should be for all patients to receive an initial triage assessment within 5 minutes of arrival to the emergency department."

One patient's record documented the patient was seen at the hospital's ED on 4/27/08 at 5:49 PM, with complaints of high blood sugars. The record documented the patient was pre-registered at 5:49 PM, and was triaged at 6:06 PM, 17 minutes after arriving at the emergency department. The patient was seen again at the hospital's ED on 5/4/08 at 11:11 PM, with complaints of an acute asthma exacerbation.

The record documented the patient was pre-registered at 11:12 PM, and was triaged at 12:06 AM, 54 minutes after arriving at the ED. Twelve of the 32 patients' ED's medical records reviewed documented that the hospital had failed to ensure that nursing staff had triaged patients within 5 minutes per the "Triage Policy".

The hospital did not ensure that nursing staff had triaged patients within 5 minutes per the "Triage Policy". A deficiency was cited at 42 CFR 482.55(a,3) for the failure of the ED's medical staff to ensure that nursing staff had triaged the patient within 5 minutes per the "Triage Policy".

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: ED patients had experienced extensively long waits to receive treatment.

Findings: Thirty-Two clinical records were reviewed of ED patients. Additionally, staff were interviewed and hospital policies were reviewed.

The hospital's "Plan for Provision of Patient Care", effective as of 3/06, stated "Patients are triaged by an RN...The purpose is to gather sufficient information to make a triage severity rating decision..."

The hospital adopted the "Emergency Severity Index" (ESI), on 2/2008 to triage ED patients. The hospital's "Triage Policy", effective as of 2/08, stated a quick triage will be completed on all patients. The some of the ESI level II indicators were described as, new onset confusion, lethargy or disorientation, severe pain greater then or equal to 7 and patients requiring two or more resources.

The Agency for Healthcare Research and Quality " http://www.ahrq.gov/research/esi/esi3.htm", stated that "ED's that practice the EMS system that the emergency nurse triages each patient and determines the priority of care based on physical, developmental and psychosocial needs as well as factors influencing access to health care and patient flow through the emergency care system...Acuity is determined by the stability of vital functions and potential for life, limb, or organ threat."

The EMS handbook dated 5/2005, stated that level 2 patients present with confusion, lethargic, disoriented or severe pain and/or distress. Some examples of high risk situations were abdominal pain, MVA with transient loss of consciousness. It also stated that "It is common for the triage nurse to identify a high-risk situation which may then be confirmed by finding abnormal vital signs."

One patient was seen at the hospital's ED on 4/27/08 at 5:49 PM, with complaints of high blood sugars, nausea and vomiting.

The record documented the patient was pre-registered at 5:49 PM, and was triaged at 6:06 PM. The patient had a history of Juvenile Diabetes and reported that her blood glucose monitor had read "High today" and that her sugars had been high for the past two weeks. The patient's pulse was 103 and her blood sugar at 6:24 PM was greater then 500. Mosby's Diagnostic and Laboratory Test Reference states that a blood sugar greater then 400 is a possible critical value and may be and indication of Diabetic Ketoacidosis a life-threatening complication. "(Diabetic Ketoacidosis untreated has a high mortality rate http://en.wikipedia.org/wiki/Diabetic ketoacidosis)." The patient was triaged as a level 3 in severity and remained in the ED lobby until 10:22 PM. The patient was admitted to the hospital at 10:40 PM, with a diagnosis of Diabetic Ketoacidosis. Seven of the 32 patient's ED's medical records that were reviewed documented that the hospital had failed to ensure that nursing staff had not assigned patient's "Emergency Severity Index" appropriately per the hospital's policies.

Nursing staff failed to ensure that nursing staff had assigned the patient's "Emergency Severity Index" appropriately. A deficiency was cited at 42 CFR 482.55(a, 3) for the failure of the ED's medical staff to ensure that nursing staff assigned the patient's "Emergency Severity Index" appropriately.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

July 30, 2008

Joseph Messmer, President and CEO
Mercy Medical Center
1512 – 12th Avenue Road
Nampa, ID 83686

CMS Certification Number: 13-0013

Dear Mr. Messmer:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on July 10, 2008. Based on a review of the deficiencies identified during this investigation, we have determined that Mercy Medical Center **is not in substantial compliance** with the Medicare hospital Condition of Participation – Emergency Services(42 Code of Federal Regulations (CFR) § 482.55).

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. Therefore, as a result of the July 10, 2008, complaint survey findings, we are required following timely notification of the accrediting body, to place the hospital under Medicare State Agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of Mercy Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable within 90 days of completion.

You may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification
Attention: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that Mercy Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When Mercy Medical Center has been found to meet all the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

for Steven Chickering
Western Consortium Survey and Certification
Division of Survey and Certification

Enclosure

cc: Debra Ransom, Idaho Bureau of Facility Standards
The Joint Commission

Mercy Medical Center

8-7-2008

Kate Mitchell
CMS – Survey and Certification
2201 Sixth Avenue, RX-48
Seattle, WA 98121

Dear Ms. Mitchell

Thank you for the opportunity to review the findings of our survey with you over the phone. Attached please find the signed CMS-2567 which includes our Plan of Correction.

Upon your receipt and review of this document we welcome any input or feedback you may be able to provide. Thanks again for your time and attention to our situation.

Respectfully yours,

Joseph Messmer
President, CEO

cc: Idaho Department of Health & Walfare

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	C 07/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY MEDICAL CENTER	1512 TWELFTH AVENUE ROAD NAMPA, ID 83686

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A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital. Surveyors conducting the investigation were: Patrick Hendrickson RN, HFS, Team Leader Gary Guiles, RN, HFS Sharon Mauzy RN, HFS Acronyms used in this report include: ADHD = Attention Deficit Hyperactivity Disorder AMA = Against Medical Advise CVA = Cerebral Vascular Accident DCS = Director of Clinical Services DT's = Delirium Tremens ETOH = Alcohol ED = Emergency Department ESI = Emergency Severity Index GERD = Gastroesophageal Reflux Disease HTN = Hypertension (High Blood Pressure) Labs = Laboratory Tests LOC = Level of Consciousness POC = Plan of Correction QAPI = Quality Assurance Performance Improvement RN = Registered Nurse TEC = Technician VS = Vital Signs	A 000	Abbreviations used in this report include: AMA = Against Medical Advice CNO = Chief Nursing Officer ED = Emergency Department EDIT = ED Improvement Taskforce ESI = Emergency Severity Index FY 09 = Fiscal Year 2009 (July 08-June 09) IT = Information Technology LIP = Licensed Independent Practitioner LWOBS = Left Without Being Seen MEC = Medical Executive Committee PI = Performance Improvement PISC = PI Steering Committee POC = Plan of Correction PSC = Patient Safety Committee QAPI = Quality Assessment Performance Improvement QLC = Quality Leadership Council QM = Quality Management On 7-9-08, the QM Director presented to the CNO a complete assessment of the hospital-wide QAPI program. The PI Plan was revised to include department-level quality indicators and a revised reporting structure. The FY 09 focus areas were identified with the CNO and will include adverse patient events, processes of care, and hospital services and operations. During the July 2008 performance evaluations the CNO met with each department director to discuss the QAPI changes, expectations, and metrics. During the first three weeks of August each Director will meet with the Quality Department to identify their department-level quality indicators, to include patient safety, high risk, or problem prone key quality indicators. The key quality indicators will be measured, analyzed, tracked, and reported in the hospital-wide Quality Leadership Council (QLC) and chaired by the CNO.	7-9-08
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations.	A 267		8-20-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joseph G. Mauzy | TITLE: Pres/CEO | (X6) DATE: 8/7/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 267	Continued From page 1 This STANDARD is not met as evidenced by: Based on review of the hospital's previous survey reports and POCS, quality improvement data and staff interview, it was determined the hospital failed to ensure its QAPI program monitored the quality and appropriateness of ED services provided to patients. This failure contributed to patients receiving incomplete triage assessments and delayed, incorrect triage of patients' emergency needs. The findings include: A previous complaint survey was conducted at the hospital on 10/1/07 through 10/3/07. During that survey it was found that policies related to triage in the ED did not match the practice of the hospital. The policy "PROTOCOL & PROCESS FOR TRIAGE AND PRE-REGISTRATION", dated September 2003, stated "All patients will be seen by the Triage nurse before pre-registration." This did not occur. A tour of the ED was conducted on 10/1/07 at 10:45 AM. Walk-in patients went to a pre-registration area and were pre-registered prior to being brought to the waiting room outside the triage area. The policy "Triage Nurses Responsibilities", not dated, stated "The triage nurse will initiate the triage process within 2-5 minutes of the patient's arrival." This did not occur. Triage did not occur for over an hour in some cases. The policy also defined Acuity Categories which called for reassessment of patients at intervals based on acuity levels. These levels included: "Level 1 - resuscitation: continuous care	A 267	On 8-20-08 all identified department-level indicators on the QAPI dashboard will be reviewed for validity, efficacy, and improvement sustainability. QAPI department-level key quality indicators will focus around patient safety, patient satisfaction, and additional department-specific metrics as needs are identified. The QLC will include administrative staff, medical staff, department directors, and QM staff. The QLC minutes and activities will be reported to the Medical Executive Committee and the Hospital's governing body. An in-depth review of all department-specific indicators will occur August 11th – 20th. This review will involve the department directors, QM Director, and PI Coordinator, to further define baselines, targets, parameters, etc. for these metrics. On 7-10-08 the QM Director, PI Coordinator, and CNO met with the ED Director to identify metrics, initially identified as; patients leaving AMA, patients LWOBS, time to triage, time to LIP evaluation as the ED indicators, in response to deficiencies cited during the survey. On 7-8-08 the CNO implemented a recruitment plan for an ED Director and to place the current Director in a developmental role as Assistant Director. On 8-7-08 the Triage Policy was reviewed and revised to assure compliance with timeframes that protect the health and safety of patients. The measure of success for adherence to the Triage Policy and Nurse's Responsibilities is 95% compliance via random sample chart audit of 30 records per month. Beginning on 8-11-08 100% of the Triage nurses will be educated and held accountable to the revised policy.	8-20-08 7-10-08 7-8-08 8-7-08 9/11/08

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A 267	Continued From page 2 Level 2 - emergent: every 15 minutes Level 3 - urgent: every 30 minutes Level 4 - semi-urgent: every 60 minutes Level 5 - non-urgent: every 120 minutes" Patient monitoring did not occur per hospital policy. A deficiency was cited on 10/3/08, at 42 CFR 482.55(a, 3), for the failure of the hospital to implement policies related to triage and monitoring of ED patients. The hospital's POC, dated 12/1/07, included "Monthly audit process being developed to review charts to assess triage and assessment times and review improvement methods based on needs." However, as of 7/9/08, monthly audits were not developed to review charts to assess triage and assessment times and review improvement methods based on needs. The QA Director and the ED Director were interviewed together on 7/9/08 at 2:15 PM. They stated that neither the hospital's QAPI program, nor the ED was performing monthly chart audits as stated in the hospital's POC. 2. Refer to A1100 Condition of Participation for Emergency Services not met and related standard level deficiency at A1104 as they relate to the failure of the hospital to ensure patients presenting to the ED were completely assessed and triaged in a timely manner, prioritized consistent with their emergency needs, and reassessed while waiting, as per the hospital's policies and procedures.	A 267	hospital-wide QAPI program was performed. The PI Plan was revised to include department-level quality indicators and a revised reporting structure. The FY 09 focus areas were identified with the CNO and will include adverse patient events, processes of care, and hospital services and operations. During the July 2008 performance evaluations the CNO met with each department director to discuss the QAPI changes, expectations, and metrics. During the first three weeks of August each Director will meet with the Quality Department to identify their department-level quality indicators, to include patient safety, high risk, or problem prone key quality indicators. The key quality indicators will be measured, analyzed, tracked, and reported in the QLC. On 7-24-08, the CNO, the physician chair of the PISC, the physician chair of the PSC, QM Director, Hospital attorney, QM Data Analyst, and Medical Staff Coordinator met to discuss proposed changes to the hospital-wide QAPI and the development of a department-specific quality indicator reporting structure. On 7-29-08 the ED Director and CNO met to discuss detailed improvements needed to adequately address triage and PI issues in the ED. On 8-6-08 the new ED Director was named with an expedited start date of 8-18-08. On 8-5-08 the EDIT met and was attended by ED leadership, ED staff, ED physicians, and the CNO. The taskforce will focus on improvement processes for triage and documentation. The EDIT began improvement activities immediately, using process flow mapping and a fishbone diagram. EDIT reports will be a recurring agenda item for MEC and the Board.	8-1-08 7-24-08 7-29-08 8-5-08
A 467	482.24(c)(2)(vi) CONTENT OF RECORD - OTHER INFORMATION	A 467		

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A 467	Continued From page 3 [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Based on staff interviews, record reviews, and review of hospital policies, it was determined the hospital failed to ensure the records of 8 of 32 ED patients (#'s 8, 9, 17, 19, 21, 22, 24, and #32), whose records were reviewed, documented triage assessment and reassessment information necessary to effectively identify and monitor the medical status of each patient. The failure to document all pertinent patient information had the potential to negatively impact patient care due to incorrect assessment and reassessment of ED patients. The findings include: 1. The hospital's "Plan for Provision of Patient Care", effective on 3/06, stated "Patients are triaged by an RN...The purpose is to gather sufficient information to make a triage severity rating decision...All assessments and examinations are documented and timed by the examiner on an appropriate portion of the medical record." The hospital adopted the "Emergency Severity Index", in 2/2008, to triage ED patients. The hospital's "Triage Policy", effective 2/08, stated a quick triage would be completed on all patients to	A 467	On 8-7-08 an ED Documentation Policy for the electronic medical record and the Plan for Provision of Patient Care were reviewed and revised to meet criteria of CHI guidelines. 100% of ED staff will be inserviced and held accountable to these policies. Failure to comply will result in disciplinary action for staff and physicians who do not meet documentation standards. The measure of success will be medical record review of 30 charts per month. All improvement efforts will be reported at the ED Medical Staff meetings by the ED Director and to the MEC and Governing Body by the CNO. On 7-29-08, the ED Improvement Taskforce identified triage as a priority improvement issue, and assigned a Triage subgroup to evaluate opportunities for improvement with guidance and oversight by ED medical staff. On 8-5-08 the Triage subgroup began meeting with medical staff participation. The Triage subgroup includes ED clinical staff and medical staff, and is facilitated by the PI Coordinator. This subgroup will report to the ED Improvement Taskforce, which includes ED physicians, the CNO, ED leadership, ED staff, and is facilitated by the QM department. The ED Improvement Taskforce will more broadly address philosophy and flow of care, as well as evaluating adjustments and improvements to the current triage process. All improvement efforts will be reported at the ED Medical Staff meetings by the ED Director and to the MEC and Governing Body by the CNO. On 8-7-08 the Triage Policy and Triage Nurse's Responsibilities were reviewed and revised to assure compliance with timeframes that protect the health and safety of patients.	8-7-08 9/30/08 9/30/08 8-7-08

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A 467	Continued From page 4 determine the ESI level. This was to be determined by clinical observation. High risk situations that included severe pain/distress and/or a pain rating of greater than or equal to 7 on a 0-10 pain scale, and patients needing a number of different types of hospital resources such as laboratory tests and X-Rays, were to be assigned a higher priority level. ED staff failed follow the above hospital policies designed to ensure patients' ED records documented necessary health status information. Examples include: A. Patient #8 was a 35-year-old female seen at the hospital's ED on 6/20/08 at 4:12 PM. The patient had thyroid surgery on 6/11/08. She had complaints of pain in her "post-thyroid surgery area", and was nauseated, dizzy and had general malaise (weakness) and a sore throat. She stated she was light headed and was shaking. The triage assessment stated the patient's pain was a 10 of 10 but did not contain clinical observations or a description of the patient's pain such as, where the pain was located, the type of pain and the description of the pain. The assessment did not include observations or an assessment of the patient's nausea, dizziness, weakness, or sore throat such as frequency, duration, or severity of symptoms; patient's appearance and functioning as it related to symptoms. This patient was sent to another hospital at 7:55 PM to rule out sepsis or an abscess of her surgery site. The hospital failed to ensure that staff documented an adequate triage assessment. B. Patient #9 was an 87-year-old female who presented to the ED on 3/20/08 at 12:12 PM, with	A 467	In September 2008 Team Health will provide additional training on ESI to all ESI-certified registered nurses. Adjustments and improvements will include an evaluation of ESI as a triage philosophy, revision of current policies, identification of target parameters, and current documentation practices. Improvements may also include evaluation and adjustment of IT systems to enhance consistency of assigning triage acuity. ED QAPI metrics will include triage indicators, and will be regularly reported to the EDIT to ensure efficacy and sustainability of improvements. Cases will be reviewed monthly by ED staff, and will be reported to the EDIT. All improvement efforts will be reported at the QLC, ED Medical Staff meetings by the ED Director, and to the MEC and Governing Body by the CNO. The following policies are in process of review and revision by a sub-committee of the Policy Review Committee that includes QM, CNO, and ED staff and physicians: 1. Triage Policy 2. Documentation in Meditech 3. Plan for Provision of Patient Care 4. Pain Assessment and Reassessment 5. ED Registration Multidisciplinary Protocol 6. ED Registration All ED staff will be inserviced and held accountable to these policies and will face disciplinary action for patterns of failure to comply. The measure of success will be medical record review of 30 charts per month. All improvement efforts will be reported at the QLC, ED Medical Staff meetings by the ED Director, and to the MEC and Governing Body by the CNO.	10-31-08 8-20-08 10-31-08 8-7-08 8-7-08 8-7-08 8-7-08 8-7-08 8-7-08

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A 467	Continued From page 5 complaints of cardiac dysrhythmias (irregular heart rate). The patient's physician had sent her from the office to the ED for an evaluation of her rapid heart rate. The patient had a history of atrial fibrillation and a pacemaker. The RN's triage assessment note at 12:23 PM, stated the patient's pulse was 210 at registration. It was not documented how this pulse rate was obtained or who took it. No evaluation of the patient was documented at that time. The triage assessment note at 12:23 PM stated the patient's pulse rate was "88-130 via pulse (oximeter)". However, the actual pulse rate documented at 12:23 was 135. The note stated the patient "denies feeling short of breath, dizzy, responsive skin w&d color pale pink". The record stated Patient #9 was taken to an examination room at 1:19 PM and then returned to the ED waiting room at 1:37 PM. Again, there was no documentation why staff made this change. The patient left the hospital AMA at 2:02 PM. The RN who was on duty 3/20/08, was interviewed on the telephone about the patient at 1:20 PM on 7/9/08. She did not recall the case with Patient #9. The hospital failed to ensure that staff had documented an adequate triage assessment per policy. C. Patient #17 was a 17-year-old male who was seen at the hospital's ED on 4/30/08 at 5:21 PM, with complaints of a head injury. The record documented the patient was triaged at 5:27 PM. The RN's triage notes documented the patient's head injury was sustained while he was playing football. It was documented the patient had reported that, "Everything went black for about 10 seconds"; he had blurred vision in the left eye and was light headed. The patient rated his pain as a	A 467	In September 2008 Team Health will provide additional training on ESI to all ESI-certified registered nurses. Adjustments and improvements will include an evaluation of ESI as a triage philosophy, revision of current policies, identification of target parameters, and current documentation practices. Improvements may also include evaluation and adjustment of IT systems to enhance consistency of assigning triage acuity. ED QAPI metrics will include triage indicators, and will be regularly reported to the EDIT to ensure efficacy and sustainability of improvements. Cases will be reviewed monthly by ED staff, and will be reported to the EDIT. All improvement efforts will be reported at the QLC, ED Medical Staff meetings by the ED Director, and to the MEC and Governing Body by the CNO. On 7-29-08, the ED Improvement Taskforce identified triage as a priority improvement issue, and assigned a Triage subgroup to evaluate opportunities for improvement with guidance and oversight by ED medical staff. On 8-5-08 the Triage subgroup began meeting with medical staff participation. The Triage subgroup includes ED clinical staff and medical staff, and is facilitated by the PI Coordinator. This subgroup will report to the ED Improvement Taskforce, which includes ED physicians, the CNO, ED leadership, ED staff, and is facilitated by the QM department. The ED Improvement Taskforce will more broadly address philosophy and flow of care, as well as evaluating adjustments and improvements to the current triage process.	10-31-08 8-20-08 9-30-08 9-30-08

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	130013	A. BUILDING _____ B. WING _____	C 07/10/2008

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A 467	Continued From page 6 9 of 10. The triage assessment did not contain documentation of the patient's LOC to include a neurological assessment that would have included, but was not limited to, observations of whether the patient was confused, lethargic or disoriented. Further, the record did not contain an assessment of his pain such as location, type and duration. Further, the assessment did not list the number of resources that the patient may such as Radiology, Nuclear Medicine or Laboratory services. The patient's Legal Representative signed the patient out AMA because of "Not enough beds" at 5:53 PM. The hospital failed to ensure that staff had documented an adequate triage assessment. D. Patient #19 was a 10-year-old male who was seen at the hospital's ED on 4/27/08 at 1:32 PM. The patient had complaints of head, hand, knee and leg injuries that were sustained when he ran into a wooden fence on a motorcycle. Triage notes documented the patient's chief complaints were head, neck, arm, hand, knee and leg injuries; he rated his pain as 8 of 10. The triage assessment did not contain documentation of the patient's LOC to include a neurological assessment that would have included, but was not limited to, observations of whether the patient was confused, lethargic or disoriented. The record did not include an assessment of the patient's injuries nor his pain. Further, the assessment did not list the number of resources that the patient may or may not have needed. At 3:22 PM, it was noted by the nurse that the patient "Left without being seen". The record did not contain documented evidence that nursing staff had reassessed the patient to include any significant symptoms, interventions, vital signs or which nurse saw the patient at/or around 2:53 PM	A 467	On 7-29-08, the ED Improvement Taskforce identified documentation as a priority improvement issue, and assigned a Documentation subgroup to evaluate opportunities for improvement. On 7-30-08 The ED Assistant Director developed an ED Medical Record audit tool. This audit tool is currently being refined. ED nursing staff will perform documentation-focused chart audits (at least 30 per month to ensure statistical significance) starting in September. Aggregated results of these audits will be reported to the ED Improvement Taskforce. The ED Documentation Improvement Taskforce is led by the ED Director and ED Assistant Director with participation by the ED Medical Staff, QM staff and ED staff. On 8-5-08 the Documentation subgroup began meeting. The Documentation subgroup includes ED staff, ED medical staff, IT representation, and is facilitated by the QM Director and/or the Clinical Quality Specialist. This subgroup will report to the ED Improvement Taskforce, which includes ED physicians, the CNO, ED leadership, ED staff, and is facilitated by the QM department. The ED Improvement Taskforce will be more broadly addressing philosophy and flow of care, as well as evaluating adjustments and improvements to the current documentation process. ED QAPI metrics will be regularly reported to the ED Improvement Taskforce to ensure efficacy and sustainability of improvements	9-30-08 8-31-08 9-30-08

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A 467	Continued From page 7 per the hospital's "Triage Policy". The hospital failed to ensure staff had documented an adequate triage assessment of the patient. E. Patient #21 was a 43-year-old male who was seen at the hospital's ED on 4/14/08, with complaints of liver pain. Triage notes documented the patient's chief complaint was abdominal pain and liver pain. The patient rated his pain as a 4 of 10. He had a past medical history of drug abuse and was hepatitis C positive. He had stopped drinking ETOH on 4/13/08. The patient had been vomiting and also suffered from anxiety and nausea. The triage assessment did not contain documented clinical observations of the patient's acute mental status to include, but not be limited to, sign and symptoms of DT's. Further, the assessment did not list the number of resources that the patient may have needed such as Laboratory, Psychiatric or Radiology services, or justify why those resources were not needed. At 11:08 AM, the patient was seated in the ED waiting room. At 12:45 and at 1:45 PM it was documented that the patient was not in the waiting room and at 1:52 PM the patient had been discharged AMA. The hospital failed to ensure that staff had documented an adequate triage assessment of the patient. F. Patient #22 was a 19-year-old female who presented to the ED on 4/27/08. She complained of upper abdominal pain and shortness of breath. The triage note stated the patient "STATES THAT YESTERDAY SHE WOKE UP WITH BILATERAL UPPER ABD PAIN MIGRATING INTO BACK. EMESIS X2." The patient's pain was documented as 8 of 10. The triage assessment did not contain documented clinical observations	A 467	All improvement efforts will be reported at the ED Medical Staff meetings by the ED Director and to the MEC and Governing Body by the CNO. On 8-5-08 the CNO arranged with the Hospital attorney for education to clinical staff regarding documentation. This education session is scheduled to occur in September 2008, and will involve all clinical departments. By 10-31-08 the ED Director, CNO, and QM Department will complete all improvement action related to this plan, for changes related to our current ED documentation. As always, the improvement of documentation is constant and on-going.	10-31-08 10-31-08

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A 467	Continued From page 8 of the patient (increased blood pressure or pulse) or her behavior (i.e. restlessness, heightened emotions, being unusually quiet) related to her acute pain. Further, the assessment did not list the number of resources that the patient may have needed or justify why those resources were not needed. The patient was sent to the waiting room. No other documentation regarding the patient's condition (i.e. pain subsiding, worsening, radiating to another part of the body) was present in the record until 7:56 PM. The note at this time stated the patient left without being seen and signed an AMA form. The hospital failed to ensure that staff had documented an adequate triage assessment. G. Patient #24 was a 37-year-old male that was seen at the hospital's ED on 4/9/08 at 7:37 PM, with a complaint of a migraine headache. He was sent to the waiting room at 7:47 PM, until he left against medical advice at 11:17 PM. Triage notes, written by the triage RN, documented the patient rated his/her pain as 10 of 10. The triage assessment did not contain documented clinical observations of the patient's mental status to include a neurological assessment or an assessment of his pain to include location, type and duration. Further, the assessment did not list the number of resources that the patient may need or justify why those resources were not needed. The hospital failed to ensure that staff had documented an adequate triage assessment. H. Patient #32 was a 71-year-old female who presented to the ED on 6/24/08 at 2:12 PM. She complained of abdominal pain. The record documented the patient was triaged at 2:22 PM. The triage note failed to document the level of abdominal pain the patient was experiencing.	A 467	See pages 4-8 for POC.	

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A 467	Continued From page 9 Her blood pressure was noted at 144/95. She was placed in the waiting room. A vital sign sheet listed the patient's blood pressure at 186/118 at 3 PM. No assessment of the patient was documented at this time. The next assessment was documented at 4:02 PM. It stated the patient's pain level was 10 of 10 and was stabbing and radiated to her perineum. No further assessment was documented at this time. At 4:20 PM, the nursing note described the patient's abdomen as tender. No further assessment was documented at this time. No pain medication was documented as being given to the patient. Nursing notes stated the patient was "UPDATED ON WAIT TIME" at 5:44 PM and given an antibiotic medication at 6:15 PM. The physician eventually saw the patient but the time of his examination was not documented. A nursing note stated the physician was in the room with the patient at 6:38 PM. She was discharged at 6:55 PM. The hospital failed to ensure information necessary to assess and monitor the patient's condition. I. On 7/9/08 at approximately 2:30 PM, the records were reviewed with the Director of Quality and Case Management and the Director of the ED. They were not able to provide any further documentation on the above patients. On 7/10/08 at approximately 1:30 PM, the Director of Medical Records stated that hospital had been struggling with documentation for many years and that the current system had many flaws. The hospital failed to ensure all necessary information was documented in patients' ED records.	A 467	See pages 4-8 for POC.	

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A 467	Continued From page 10 2. The hospital's "Triage Policy", effective 2/08, stated "Patient's waiting to be taken to the treatment area will have a reassessment completed and documented hourly. The reassessment will include vital signs, (tec may assist obtaining vs), and a notation indicating which nurse saw that patient. Any other interventions provided will also be documented. Any significant symptoms should be reassessed..." On 7/10/08, two nurses, who worked as triage nurses, stated they often check ED patients in the ED lobby but do not chart the reassessments in patients' medical records. The hospital failed to ensure all necessary information was documented in patients' ED records.	A 467	See pages 4-8 for POC.	
A1100	482.55 EMERGENCY SERVICES The hospital must meet the emergency needs of patients in accordance with acceptable standards of practice. This CONDITION is not met as evidenced by: Based on staff interviews and review of hospital policies and patient records, it was determined the hospital failed to ensure patients presenting to the ED received timely, appropriate triage assessments and reassessments to meet their medical needs. The findings include: 1. Refer to A267 as it relates to the failure of the hospital to ensure its QAPI program monitored	A1100	Please refer to POCs for tags A 267, A 467, and A 1104. Cited deficiencies are referrals to these standards.	

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A1100	Continued From page 11 the quality and appropriateness of ED services provided to patients. 2. Refer to A467 as it relates to the failure of the hospital to ensure patients' ED records documented triage assessment and reassessment information necessary to effectively identify and monitor the medical status of each patient. 3. Refer to A1104, as it relates to the failure of the hospital to ensure its medical staff provided sufficient oversight of the implementation of ED policies to ensure patients presenting to the ED were completely assessed and triaged in a timely manner, prioritized consistent with their emergency needs, and reassessed while waiting for a medical screening examination. The cumulative effect of these negative facility practices significantly impeded the hospital's ability to provide safe, effective services to patients seeking ED services.	A1100	Please refer to POCs for tags A 267, A 467, and A 1104. Cited deficiencies are referrals to these standards.	
A1104	482.55(a)(3) EMERGENCY SERVICES POLICIES [If emergency services are provided at the hospital ---] The policies and procedures governing medical care provided in the emergency service or department are established by and are a continuing responsibility of the medical staff. This STANDARD is not met as evidenced by: Based on staff interviews and review of hospital policies and patient records, it was determined	A1104	On 8-5-08 the Clinical Leadership Team identified the need for improvement in regular review and revision of Hospital-wide policies. The QM Department will oversee the process, facilitate meetings, and will arrange for policies to be placed on the Mercy Medical Center Intranet. All policies that affect Medical Staff or Departments that have a Medical Director must be approved by the appropriate Medical Staff Department chair. ED polices related to documentation and triage will be reviewed and revised as needs are identified. These polices will go to the Policy Review Committee beginning August 2008. The policy on policies will be reviewed and revised at the initial meeting	8-22-08

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A1104	Continued From page 12 the hospital failed to ensure its medical staff provided sufficient oversight of the implementation of ED policies to ensure patients presenting to the ED were completely assessed and triaged in a timely manner, prioritized consistent with their emergency needs, and reassessed while waiting for a medical screening examination. One or more of these issues were noted for 14 of 32 ED patients (#'s 2, 5, 8, 9, 14, 16, 17, 19, 20, 21, 22, 23, 24 and 32) whose records were reviewed. This resulted in delayed treatment for patients experiencing serious, some potentially life threatening, medical conditions. The findings include: The hospital's "Plan for Provision of Patient Care", effective on 3/06 and still in effect as of the time of the survey, stated "Patients are triaged by an RN...The purpose is to gather sufficient information to make a triage severity rating decision...assessments and examinations are documented and timed by the examiner on an appropriate portion of the medical record...assessment and should be timely and brief....The goal should be for all patients to receive an initial triage assessment within 5 minutes of arrival to the emergency department..." The hospital adopted the "Emergency Severity Index (ESI)" on 2/2008 to triage ED patients. The ESI included 5 levels of patient triaging with level I being the highest priority. The hospital's ESI Level II indicators were described as new onset confusion, lethargy or disorientation, severe pain greater than or equal to 7, and patients requiring two or more resources. It indicated Level II patients should be admitted immediately to the main ED and a complete (full) triage and nursing	A1104	On 7-24-08 the CNO meet with the administrative management for EMCARE, which is the company that employees the emergency department physicians. At this meeting, contractual obligations were reviewed and administration will monitor for compliance with the duties assumed in the contract. Physician involvement in department PI, patient flow, and overall physician oversight of care processes and standards in the Mercy Medical Center Emergency Department were clarified. The ED Director and CNO will monitor compliance to the contract. The following policies are in process of review and revision by a sub-committee of the Policy Review Committee that includes QM, CNO, and ED staff and physicians: 7. Triage Policy 8. Documentation in Meditech 9. Plan for Provision of Patient Care 10. Pain Assessment and Reassessment 11. ED Registration Multidisciplinary Protocol 12. ED Registration All ED staff will be inserviced and held accountable to these policies and will face disciplinary action for patterns of failure to comply. The measure of success will be medical record review of 30 charts per month. All improvement efforts will be reported at the QLC, ED Medical Staff meetings by the ED Director, and to the MEC and Governing Body by the CNO. In September 2008 Team Health will provide additional training on ESI to all ESI-certified registered nurses.	7-24-08 8-7-08 8-7-08 8-7-08 8-7-08 8-7-08 8-7-08 9-30-08

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A1104	Continued From page 13 assessment completed. The hospital's ESI Level III indicators were described as patients requiring two or more resources with vital signs not in danger zone. It further noted Level III patients would be seen in the ED but could wait in the ED lobby until there was a room available. The ESI handbook, dated 5/2005, stated Level II patients present with confusion, lethargy, disorientation or severe pain and/or distress. Some examples of Level II patient high risk situations were abdominal pain and MVA (motor vehicle accident) with transient loss of consciousness. It also stated that "It is common for the triage nurse to identify a high-risk situation which may then be confirmed by finding abnormal vital signs." The hospital's "Triage Policy", effective 2/08, stated "A quick triage ...will be completed on all patients...Patient's waiting to be taken to the treatment area will have a reassessment completed and documented hourly. The reassessment will include vital signs, (tec may assist obtaining vs), and a notation indicating which nurse saw that patient. Any other interventions provided will also be documented. Any significant symptoms should be reassessed..." The Agency for Healthcare Research and Quality " http://www.ahrq.gov/research/esi/esi3.htm", stated in EDs that practice the ESI system that the " emergency nurse triages each patient and determines the priority of care based on physical, developmental and psychosocial needs as well as factors influencing access to health care and patient flow through the emergency care	A1104	Adjustments and improvements will include an evaluation of ESI as a triage philosophy, revision of current policies, identification of target parameters, and current documentation practices. Improvements may also include evaluation and adjustment of IT systems to enhance consistency of assigning triage acuity. See pages 4-8 for POC.	10-31-08

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A1104	Continued From page 14 system...Acuity is determined by the stability of vital functions and potential for life, limb, or organ threat." The hospital failed to ensure the Medical Staff provided ongoing monitoring of ED services and that staff correctly implemented the ESI as described above. Examples include: 1. Patient #2 was a 34-year-old female that was seen at the hospital's ED on 4/27/08 at 5:49 PM. The patient had complaints of high blood sugars, nausea and vomiting. The record documented the patient was pre-registered at 5:49 PM, and was triaged at 6:06 PM, 17 minutes after arriving at the ED. The patient had a history of juvenile diabetes and reported that her blood glucose monitor had read "High today" and that her sugars had been high for the past two weeks. The triage assessment stated the patient's pulse was 103 and her blood sugar at 6:24 PM, was greater then 500. Mosby's Diagnostic and Laboratory Test Reference (1998), states that a blood sugar greater than 400 is a possible critical value and may be an indication of Diabetic Ketoacidosis, a life-threatening complication. Diabetic Ketoacidosis, untreated, has a high mortality rate. The patient was triaged as a level III, contradicting the hospital's ESI as the patient had critical lab values, abnormal vital signs and a life threatening condition; all indicators of ESI level II. The triage assessment did not list the number of resources the patient may have needed. The patient was placed in the ED lobby until 8:25 PM. The record did not contain documented evidence that nursing staff had reassessed the patient hourly per the hospital's "Triage Policy". Further, there was no documented evidence that the triage nurse	A1104	On 7-24-08 the CNO meet with the administrative management for EMCARE, which is the company that employees the emergency department physicians. At this meeting, contractual obligations were reviewed and administration will monitor for compliance with the duties assumed in the contract. Physician involvement in department PI, patient flow, and overall physician oversight of care processes and standards in the Mercy Medical Center Emergency Department were clarified. The ED Director and CNO will monitor compliance to the contract. Regular monitoring and documentation on all waiting patients will begin. The CNO, ED Director, and Assistant Director will evaluate the staffing matrix to ensure that this monitoring role is being consistently staffed.	7-24-08 8-12-08

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A1104	Continued From page 15 notified the physician of the initial blood sugar reading that was taken at 6:24 PM. Venous blood samples were drawn at 7:29 PM, and the results were a "critical" blood sugar of 584. The results were called to the ED at 8:24 PM. The physician saw the patient at 9:34 PM, and documented the patient's condition as being "anxious, tachypneic (rapid breathing) and positive Ketonic odor on breath (sweet smell)." On 7/09/08 at approximately 2:30 PM, the nurse that triaged the patient was questioned via telephone. He could not remember the case. On 7/8/08 at 2:45 PM, the ED Director reviewed the patient's record. He stated the patient should have been triaged as a level II and that "yes, this was an emergency situation." He could not find documented evidence that the triage nurse had notified the physician of the initial blood sugar result. The hospital failed to ensure that nursing had assigned the patient's "Emergency Severity Index" appropriately. The hospital failed to ensure that nursing identified the patient's blood sugar as an indication of Diabetic Ketoacidosis which was a life-threatening complication. The hospital failed to ensure that the triage nurse communicated with the ED Physician and notified the physician of the patient's initial blood sugar results. The hospital failed to ensure that staff had reassessed the patient hourly to include any significant symptoms, interventions, vital signs or which nurse saw that patient per the hospital's "Triage Policy". 2. Patient #2 was seen again at the hospital's ED on 5/4/08 at 11:11 PM, with complaints of an acute asthma exacerbation. The record documented the patient was pre-registered at	A1104	See pages 4-8, 15 for POC.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1104	Continued From page 16 11:12 PM, and was triaged at 12:06 AM, 54 minutes after arriving at the emergency department. The hospital failed to ensure that staff triaged the patient within 5 minutes per the "Triage Policy". 3. Patient #5 was a 1-year-old male who was seen at the hospital's ED on 4/15/08. The patient's parents reported the child was short of breath. The record documented the patient was pre-registered at 5:45 PM, and was triaged at 6:01 PM, 16 minutes after arriving at the emergency department. The hospital failed to ensure that staff triaged the patient within 5 minutes per the "Triage Policy". 4. Patient #8 was a 35-year-old female seen at the hospital's ED on 6/20/08. The patient had thyroid surgery on 6/11/08 and had complaints of pain in her "post-thyroid surgery area", and was nauseated, dizzy and had general malaise (weakness) and a sore throat. She stated she was light headed and was shaking. The record documented the patient was pre-registered at 4:12 PM and triaged at 4:26 PM, 14 minutes after arriving at the emergency department. The triage assessment stated the patient's pain was a 10 of 10 but did not contain clinical observations or a description of the patient's pain. The patient was triaged as a level III, contradicting the hospital's ESI as the patient reported severe pain, an indicator of level II triage assignment. The patient was sent to another hospital at 7:55 PM to rule out sepsis or an abscess at the sight of her surgery site. 5. Patient #9 was an 87-year-old female who presented to the ED on 3/20/08 at 12:12 PM, with complaints of cardiac dysrhythmias (irregular	A1104	See pages 4-8, 15 for POC	

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	130013	A. BUILDING _____ B. WING _____	C 07/10/2008

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A1104	Continued From page 17 heart rate). The patient's physician had sent her from the office to the ED for an evaluation of her rapid heart rate. The patient had a history of atrial fibrillation and a pacemaker. The record documented the patient pre-registered at 12:22 PM and was triaged at 12:37 PM, 15 minutes after arriving at the emergency department. The triage assessment note at 12:23 PM, stated the patient's pulse was 210 at registration. It was not documented how this pulse rate was obtained or who took it. No evaluation of the patient was documented at that time. The triage assessment note at 12:23 PM stated the patient's pulse rate was "88-130 via pulse (oximeter)". However, the actual pulse rate documented at 12:23 was 135. The note stated the patient "denies feeling short of breath, dizzy, responsive skin w&d color pale pink". The nurse gave the patient a priority level II, which meant the patient was to be taken back to an examination room in the ED and examined by a physician on a priority basis. Instead, the patient was sent to the waiting room until 1:19 PM. No documentation was present as to why the triage protocol was not followed. The record stated Patient #9 was taken to an examination room at 1:19 PM and then returned to the ED waiting room at 1:37 PM. Again, there was no documentation why staff made this change. The patient left the hospital AMA at 2:02 PM. The RN who was on duty 3/20/08, was interviewed on the telephone about the patient at 1:20 PM on 7/9/08. She did not recall the case with Patient #9. 6. Patient #14 was a 1-year-old female that was seen at the hospital's ED on 5/4/08 at 12:22 PM. She was brought to the hospital by her parent who complained the child had an inability to go to	A1104	See pages 4-8, 15 for POC	

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A1104	Continued From page 18 the bathroom. The record documented the patient was pre-registered at 12:36 PM. The record did not contain a triage assessment. At 2:22 PM, the record stated the "Patient discharged from ED" and at 7:06 PM, it was noted by the nurse that the patient "Left without being seen." The record did not contain documented evidence that nursing staff had triaged the patient. 7. Patient #16 was a 78-year-old female who was seen at the hospital's ED on 5/15/08 at 10:23 PM, with complaints of high blood sugars. The record documented the patient was triaged at 10:27 PM, and was seated in the ED waiting room at 10:31 PM. At 12:23 AM, it was noted by the nurse that the patient was "Feeling better and that she wants to go home..." The patient left without being seen at that time. The record did not contain documented evidence that nursing staff had reassessed the patient hourly per the hospital's "Triage Policy". 8. Patient #17 was a 17-year-old male who was seen at the hospital's ED on 4/30/08, with complaint of a head injury. The record documented the patient was triaged at 5:27 PM. The triage notes documented the patient's head injury was sustained while he was playing football. It was documented the patient had reported that, "Everything went black for about 10 seconds", he had blurred vision in the left eye and was light headed. The patient rated his pain as a 9 of 10. The patient was triaged as a level III, contradicting the hospital's ESI as the patient had reported severe pain and a change in LOC, consistent with triage level II. The triage assessment did not contain documentation of the patient's LOC to include a neurological	A1104	See pages 4-8, 15 for POC.	

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A1104	Continued From page 19 assessment that would have included, but was not limited to, observations of whether the patient was confused, lethargic or disoriented. The record did not include an assessment of the patient's injuries or his pain. Further, the assessment did not list the number of resources that the patient may have needed. The patient was triaged as a level III contradicting the hospital's ESI the patient had reported severe pain and had a change of LOC at the time of the injury; all consistent with level II triage criteria. The patient's Legal Representative signed the patient out AMA because of "Not enough beds". The hospital failed to ensure that staff had assigned the patient's "Emergency Severity Index" per the hospital's policy and ensure that staff had properly assessed the patients LOC and pain. 9. Patient #19 was a 10-year-old male who was being seen at the hospital's ED on 4/27/08 at 1:32 PM, with complaints of head, hand, knee and leg injuries that were sustained when he ran into a wooden fence on a motorcycle. The record documented the patient was pre-registered at 1:32 PM, and was triaged at 1:53 PM, 21 minutes after arriving at the emergency department. Triage notes documented the patient's chief complaint was head, neck, arm, hand, knee and leg injuries; he rated his pain as an 8 of 10. The patient was triaged as a level III, contradicting the hospital's ESI as the patient had reported severe pain; an indication for level III prioritization. The triage assessment did not contain documentation of the patient's LOC to include a neurological assessment that would have included, but was not limited to, observations of whether the patient being confused, lethargic or disoriented. The record did not include an assessment of the	A1104	See pages 4-8, 15 for POC.	

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A1104	Continued From page 20 patient's injuries or his pain. Further, the assessment did not list the number of resources that the patient may or may not have needed. At 3:22 PM, it was noted by the nurse that the patient "Left without being seen". The record did not contain documented evidence that nursing staff had reassessed the patient hourly per the hospital's "Triage Policy". The hospital failed to ensure Patient #19 received care and services consistent whit his needs and hospital policies. 10. Patient #20 was a 19-year-old male who was seen at the hospital's ED on 4/5/08 at 2:43 PM, with complaints of head pain and trouble seeing following a motor-vehicle accident. The record documented the patient was pre-registered at 2:44 PM, and was triaged at 2:57 PM, 13 minutes after arriving at the emergency department. The record did not include an assessment of the patient's LOC that would have included observations of whether the patient was confused, lethargic or disoriented. Additionally, there no documented assessment of his injuries or his pain. The patient left the ED at 4:30 PM AMA. 11. Patient #21 was a 43-year-old male who was seen at the hospital's ED on 4/14/08, with complaints of liver pain. The record documented the patient was pre-registered at 10:47 AM, and was triaged at 11:06 AM, 19 minutes after arriving at the emergency department. Triage notes documented the patient's chief complaint was abdominal pain and liver pain. The patient rated his pain as a 4 of 10. He had a past medical history of drug abuse and was hepatitis C positive. He had stopped drinking ETOH on 4/13/08. The patient had been vomiting and also suffered from anxiety and nausea. The triage	A1104	See pages 4-8, 15 for POC.	

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A1104	Continued From page 21 assessment did not contain documented clinical observations of the patient's acute mental status to include, sign and symptoms of DT's and a description of his pain. Further, the assessment did not list the number of resources that the patient may have needed, or justify why those resources were not needed. At 11:08 AM, the patient was seated in the ED waiting room. At 12:45 and at 1:45 PM it was documented that the patient was not in the waiting room and at 1:52 PM the patient had been discharged AMA. The hospital failed to ensure staff had triaged the patient within 5 minutes per the "Triage Policy", and that the triage assessment included clinical observations of the patient's LOC to include the patient's acute mental status and assessment of his pain. 12. Patient #22 was a 19-year-old female who presented to the ED on 4/27/08. She complained of upper abdominal pain and shortness of breath. Pre-registration was completed at 6:53 PM. The patient was triaged at 7:35 PM, 45 minutes after arriving at the ED. The triage note stated the patient "STATES THAT YESTERDAY SHE WOKE UP WITH BILATERAL UPPER ABD PAIN MIGRATING INTO BACK. EMESIS X2." The patient's pain was documented as 8 of 10. The patient was triaged as a level III, contradicting the hospital's ESI as the patient had reported severe pain, an indicator for level II assignment. The triage assessment did not contain documented clinical observations of the patient's behavior related to her acute pain. Further, the assessment did not list the number of resources that the patient may have needed or justify why those resources were not needed. The patient was sent to the waiting room. No other documentation regarding the patient's condition	A1104	See pages 4-8, 15 for POC.	

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A1104	Continued From page 22 was present in the record until 7:56 PM. The nursing note at this time stated the patient left without being seen and signed an AMA form. An interview was conducted with the ED Director on 7/6/08 at 2:00 PM. He could not explain why the Patient #22 received an ESI Level III rating. He also verified that there was no documentation to support the Level III rating. The hospital failed to ensure that staff had triaged the patient within 5 minutes per the "Triage Policy", assigned the patient's ESI appropriately and had properly assessed the clinical observations of the patient's acute mental status, pain, injuries and the number of resources that the patient may need, or justify why those resources were not needed. 13. Patient #23 was an 18-year-old male who presented to the ED on 3/5/08 at 4:24 PM. The patient had complaints of an irregular heart beat and chest pain and was assigned as a level II. The patient was taken into the ED room at 5:08 PM and cardiac rhythms were obtained. The next nursing note, at 6:53 PM, stated, "Room found empty, apparently left without being seen." There was no documented evidence that staff provided a complete (full) triage and nursing assessment of the patient. Further, there was no documented evidence that the ED physician had seen the patient. 14. Patient #24 was a 37-year-old male that was seen at the hospital's ED on 4/9/08, with complaints of migraine headache. The record documented the patient was pre-registered at 7:37 PM, and was triaged at 7:46 PM, 9 minutes after arriving at the emergency department. He	A1104	See pages 4-8, 15 for POC.	

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A1104	Continued From page 23 was sent to the waiting room at 7:47 PM and left against medical advice at 11:17 PM. Triage notes documented the patient rated his pain as 10 of 10. The patient was triaged as a Level III, contradicting the hospital's ESI as the patient had reported severe pain, indicating Level II assignment. The triage assessment did not contain documented clinical observations of the patient's mental status to include a neurological assessment or an assessment of his acute pain. Further, the assessment did not list the number of resources the patient may need. The record did not contain documented evidence of hourly reassessments per the hospital's "Triage Policy". Lastly, there was no re-assessment of the patient when he left against medical advice at 11:17 PM. An interview was conducted with the ED Director on 7/6/08 at 2:00 PM. He could not explain why Patient #24 was not seen by the physician. He also verified that there was no documentation in the record to support Level III triage assignment. The hospital failed to ensure that staff had triaged the patient within 5 minutes per the "Triage Policy", assigned the patient's ESI appropriately, and had properly assessed the clinical observations of the patient's acute mental status, performed an assessment of his pain and the number of resources the patient may have needed. The hospital also failed to ensure that staff reassessed the patient hourly per the hospital's "Triage Policy". 15. Patient #32 was a 71-year-old female who presented to the ED on 6/24/08 at 2:12 PM. She complained of abdominal pain. The record documented the patient was triaged at 2:22 PM, 10 minutes after arriving at the emergency	A1104	See pages 4-8, 15 for POC..	

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A1104	Continued From page 24 department. The triage nurse assigned the patient as a Level III. The triage note failed to document the level of abdominal pain the patient was experiencing. Her blood pressure was noted at 144/95. She was placed in the waiting room. A vital sign sheet listed the patients blood pressure at 186/118 at 3 PM. No assessment of the patient was documented at this time. The next assessment was documented at 4:02 PM. It stated the patient's pain level was 10 of 10 and was stabbing and radiated to her perineum. No further assessment was documented at this time. At 4:20 PM, the nursing note described the patient's abdomen as tender. No further assessment was documented at this time. No pain medication was documented as being given to the patient. Nursing notes stated the patient was "UPDATED ON WAIT TIME" at 5:44 PM and given an antibiotic medication at 6:15 PM. The physician eventually saw the patient but the time of his examination was not documented. A nursing note stated the physician was in the room with the patient at 6:38 PM. She was discharged at 6:55 PM. During a telephone interview on 7/9/08 at 1:55 PM, the triage RN for Patient #32 stated that he did not remember the patient. On 7/14/08, the hospital administrator provided a second set of the patient's records. The records were reviewed and confirmed the hospital failed to ensure that the patient had been triaged within 5 minutes per the "Triage Policy". Further, the hospital failed to ensure that staff had assigned the patient's "Emergency Severity Index" appropriately per the hospital's policies and procedures.	A1104	See pages 4-8, 15 for POC.	

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A1104	Continued From page 25 16. On 7/9/08 at 10:26 AM, a patient was observed in the ED lobby. The triage nurse stated at that time that she needed to check in with the patient because she has not been able to triage the patient yet and it had been 48 minutes since the patient had arrived. 17. On 7/9/08, at approximately 2:30 PM, all of the previously referenced patient records were reviewed with the Director of Quality and Case Management and the Director of the ED. They were not able to provide any further documentation on the above patients. The Medical Director for Emergency Services was interviewed on 7/10/08 at 10:30 AM. He stated he was aware of a deficiency related to the triaging of patients in the ED in October 2007. He stated he was not involved in the plan of correction or in improving the triage system including patient monitoring. He said the medical staff had approved a new triage policy but he had not been involved with the development or implementation of the system to triage patients. He said he was not aware of problems related to triaging patients. He acknowledged problems due to space limitations during renovation of the ED and said patients had to wait until rooms became available. He stated he was not aware of documentation of medical staff involvement related to the development of systems for patient care in the ED. The hospital's Medical Staff failed to ensure that the hospital's policies and procedures were followed with regards to adequately and completely assessing and triaging patients in a timely manner and reassessing patients who were waiting in the ED's lobby.	A1104	On 7-24-08 the CNO meet with the administrative management for EMCARE, which is the company that employees the emergency department physicians. At this meeting, contractual obligations were reviewed and administration will monitor for compliance with the duties assumed in the contract. Physician involvement in department PI, patient flow, and overall physician oversight of care processes and standards in the Mercy Medical Center Emergency Department were clarified. The ED Director and CNO will monitor compliance to the contract. Regular monitoring and documentation on all waiting patients will begin. The CNO, ED Director, and Assistant Director will evaluate the staffing matrix to ensure that this monitoring role is being consistently staffed. The CNO, ED Director, and Assistant Director will evaluate the staffing matrix to ensure that this monitoring role is being consistently staffed. On 8-5-08 the Clinical Leadership Team identified the need for improvement in regular review and revision of Hospital-wide policies. The QM Department will oversee the process, facilitate meetings, and will arrange for policies to be placed on the Mercy Medical Center Intranet. All policies that affect Medical Staff or Departments that have a Medical Director must be approved by the appropriate Medical Staff Department chair. ED polices related to documentation and triage will be reviewed and revised as needs are identified. These polices will go to the Policy Review Committee beginning August 2008. The policy on policies will be reviewed and revised at the initial meeting on 8-22-08 and will be approved by Medical Staff.	7-24-08 8-12-08 8-22-08

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A1104	Continued From page 26 Without following the newly established policy for ESI, the nursing staff compromised the health and well-being of patients who meet the criteria of a high risk patient. Patients may face a deteriorating health condition or possibly death, should the ESI system be used incorrectly.	A1104	See pages 4-8, 15 for POC.	

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

August 20, 2008

Joseph Messmer, President and CEO
Mercy Medical Center
1512 – 12th Avenue Road
Nampa, ID 83686

CMS Certification Number: 13-0013

Dear Mr. Messmer:

The Centers for Medicare and Medicaid Services (CMS) is in receipt of Mercy Medical Center's voluntarily-submitted plan of correction in response to the complaint survey conducted July 10, 2008, by the Idaho Bureau of Facility Standards (State agency). The plan of correction was reviewed by both CMS and the State agency and was found to be credible. CMS appreciates the time and effort that Mercy Medical Center has taken to address their commitment to safe, quality patient care.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Kate Mitchell

for Steven Chickering
Western Consortium Survey and Certification
Division of Survey and Certification

cc: Debra Ransom, Idaho Bureau of Facility Standards

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3315 1828

August 25, 2008

Joseph Messmer
Mercy Medical Center
1512 – 12th Avenue Road
Nampa, Idaho 83686

RE: Mercy Medical Center, provider #130013

Dear Mr. Messmer:

Based on the complaint survey completed at Mercy Medical Center on July 10, 2008 by our staff, we have determined that Mercy Medical Center is out of compliance with the Medicare Hospital Conditions of Participation on Emergency Services (42 CFR 482.55). To participate as a provider of services in the Medicare Program, a hospital must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 8, 2008**, and keep a copy for your records.

Also pursuant to the provisions of IDAPA 16.03.14.150.01.g, Mercy Medical Center is being issued a Provisional hospital license. The license is enclosed and is effective July 10, 2008, through November 10, 2008. The conditions of the provisional license are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware, that failure to comply with the conditions of the provisional license, may result in further action being taken against the hospital's license.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit to the State Survey Agency a written request by **September 19, 2008**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review. Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
P.O. Box 83720
Boise, ID 83720-0036
phone: (208)364-1804
fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues which are not raised at an administrative review may not later be raised at higher level hearings (IDAPA 16.05.03.301).

We urge you to begin correction immediately.

If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

SYLVIA CRESWELL, Supervisor
Non-Long Term Care

SC/mlw

Enclosures

Mercy Medical Center

August 28, 2008

Ms. Sylvia Creswell
Idaho Department of Health & Welfare
Bureau of Facility Standards
3232 Elder Street
Boise, ID 83720-0036

Dear Ms. Creswell:

This letter is in response to your letter dated August 25, 2008, requesting a Plan of Correction from the survey by your office on July 10, 2008, of the Emergency Services at Mercy Medical Center.

Attached please find the signed State Form P06111 with Tag references to the action plan Mercy Medical Center submitted to CMS, with a copy to your office, August 7, 2008, on CMS form 2567. This format and referencing was completed as a result of a phone conversation between you and our CNO, Clint Child, on August 26, 2008. We are also enclosing an additional copy of our plan submitted August 7, 2008, for your referencing convenience.

We regret the delay in receiving the request from your office for the Plan of Correction on the State Form P06111. Had we received this request earlier, as you stated, we could have completed the form with the CMS Plan of Correction without undue duplication of efforts and without having to pull resources from ongoing actions associated with the Plan of Correction.

We are also enclosing a copy of a letter from Mr. Steven Chickering from the CMS Division of Survey and Certification. This letter from Mr. Chickering was in response to our Plan of Correction submitted to CMS on August 7, 2008, informing Mercy Medical Center that the plan had been received, reviewed by both CMS and the State agency and found to be credible. Debra Ransom of the Idaho Bureau of Facility Standards was copied this letter by Mr. Chickering's office.

As I hope you are aware, we at Mercy Medical Center take the compliance with all standards and regulations very seriously. Our corrective action steps began during the

survey in July with the initial formulation and actions for a Plan of Correction on items identified. Many items discussed in the Exit Interview with your staff on July 10, 2008, had actions taken prior to the receipt of the official findings from CMS as a result of the State report.

After your receipt and review of this action plan we welcome any input or feedback you may be able to provide.

Respectfully,

Joseph Messmer,
President, CEO

Enclosures

1) State Form P06111
2) Copy of plan submitted on August 7, 2008
3) Copy of Letter from Mr. Steven Chickering

cc: Debra Ransom
Dick Armstrong

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130013	A. BUILDING _____ B. WING _____	C 07/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY MEDICAL CENTER	1512 TWELFTH AVENUE ROAD NAMPA, ID 83686

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
B 000	16.03.14 Initial Comments The following deficiencies were cited during the complaint survey of your hospital. Surveyors conducting the investigation were: Patrick Hendrickson RN, HFS, Team Leader Gary Guiles, RN, HFS Sharon Mauzy RN, HFS Acronyms used in this report include: ADHD = Attention Deficit Hyperactivity Disorder AMA = Against Medical Advise CVA = Cerebral Vascular Accident DCS = Director of Clinical Services DT's = Delirium Tremens ETOH = Alcohol ED = Emergency Department ESI = Emergency Severity Index GERD = Gastroesophageal Reflux Disease HTN = Hypertension (High Blood Pressure) Labs = Laboratory Tests LOC = Level of Consciousness POC = Plan of Correction QAPI = Quality Assurance Performance Improvement RN = Registered Nurse TEC = Technician VS = Vital Signs	B 000	RECEIVED AUG 29 2008 FACILITY STANDARDS	
BB124	16.03.14.200.10 Quality Assurance 10. Quality Assurance. Through administration and medical staff, the governing body shall ensure that there is an effective, hospital-wide quality assurance program to evaluate the provision of care. The hospital must take and document appropriate remedial action to address	BB124	Refer to corrective action identified in Tag #A267 in Mercy Medical Center's Plan of Correction submitted 8/7/08, on Form CMS-2676 (Page 1-3)	

Bureau of Facility Standards

Joseph A. Mar

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Pres/CEO (X6) DATE 8/27/08

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BB124	Continued From page 1 deficiencies found through the program. The hospital must document the outcome of the remedial action. (10-14-88) This Rule is not met as evidenced by: Based on review of the hospital's previous survey reports and POCS, quality improvement data and staff interview, it was determined the hospital failed to ensure its QAPI program monitored the quality and appropriateness of ED services provided to patients. The findings include: 1. Refer to A0267 as it relates to the failure to ensure its QAPI program monitored the quality and appropriateness of ED services provided to patients. 2. Refer to A1100 Condition of Participation for Emergency Services not met and related standard level deficiency at A1104 as they relate to the failure of the hospital to ensure patients presenting to the ED were completely assessed and triaged in a timely manner, prioritized consistent with their emergency needs, and reassessed while waiting, as per the hospital's policies and procedures. This failure contributed to patients receiving incomplete triage assessments and delayed, incorrect triage of patients' emergency needs.	BB124		
BB297	16.03.14.370.01 Emergency Service, Policies and Procedures 370. EMERGENCY SERVICE. All hospitals who provide emergency medical care in a specific area of the facility shall have an organized plan for emergency care based upon current community needs and the capability of the hospital. (10-14-88)	BB297	Refer to corrective action identified in Tag #A1100 in Mercy Medical Center's Plan of Correction submitted 8/7/08, on Form CMS-2676 (Page 11-15)	

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BB297	Continued From page 2 01. Policies and Procedures. The emergency room of every hospital shall have written policies and procedures. These shall be in conformance with state and local laws. The procedures shall be approved by the hospital administration, medical staff, and nursing service. The policies shall be approved by the governing body. The policies and procedures shall include but are not limited to, the following: (10-14-88) a. Policies and procedures for handling accident victims, rape victims, contagious disease, persons suspected of criminal acts, abused children or adults, emotionally disturbed persons, persons under the influence of drugs and/or alcohol, persons contaminated by radioactive materials, and patients dead on arrival; and (10-14-88) b. Medical responsibility shall be delineated regarding emergency care (including levels of care relating to clinical privileges and specialty areas) and shall specify a method to insure staff coverage; and (10-14-88) c. Procedures that can/cannot be performed in the emergency room; and (10-14-88) d. Policies and supporting procedures for referral and/or transfer to another facility; and (10-14-88) e. Policies regarding instructions to be given patients requiring follow-up services; and (10-14-88) f. Policies and supporting procedures for storage of equipment, medication, and supplies; and (10-14-88)	BB297		

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BB297	Continued From page 3 g. Policy and supporting procedures for care of emergency equipment; and (10-14-88) h. Instructions for procurement of drugs, equipment, and supplies; and (10-14-88) i. Policy and supporting procedures involving toxicology; and (10-14-88) j. Policy and supporting procedures devised for notification of patient's physician and transmission of reports; and (10-14-88) k. Policy involving instructions relative to disclosure of patient information; and (10-14-88) l. A policy for integration of the emergency room into a disaster plan. (10-14-88) This Rule is not met as evidenced by: Based on staff interviews and review of hospital policies and patient records, it was determined the hospital failed to ensure patients presenting to the ED received timely, appropriate triage assessments and reassessments to meet their medical needs. The findings include: 1. Refer to A267 as it relates to the failure of the hospital to ensure its QAPI program monitored the quality and appropriateness of ED services provided to patients. 2. Refer to A467 as it relates to the failure of the hospital to ensure patients ' ED records documented triage assessment and reassessment information necessary to effectively identify and monitor the medical status of each patient. 3. Refer to A1104, as it relates to the hospital's	BB297		

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BB297	Continued From page 4 staff's failure to adequately and completely assess and triage patients in a timely manner. Further, staff failed to adequately assign patient's "Emergency Severity Index", and failed to reassess patients who were waiting in the ER's lobby per hospital policies. The cumulative effect of these negative facility practices significantly impeded the hospital ' s ability to provide safe, effective services to patients seeking ED services.	BB297		
BB300	16.03.14.370.04 Records 04. Records. Medical records shall be kept on every patient who presents himself for treatment in the emergency room of the hospital. (10-14-88) a. The record shall contain at least the following: (10-14-88) i. Patient identification; and (10-14-88) ii. Time of arrival; and (10-14-88) iii. Description of illness or injury; and (10-14-88) iv. Clinical, laboratory and x-ray findings as appropriate; and (10-14-88) v. Diagnosis, physician orders, medication, and treatment given; and (10-14-88) vi. Condition of patient on discharge or transfer; and (10-14-88) vii. Final disposition and time of day; and (10-14-88) viii. Instructions for follow-up care; and (10-14-88)	BB300	Refer to corrective action identified in Tag #A467 in Mercy Medical Center's Plan of Correction submitted 8/7/08, on Form CMS-2676 (Page 3-8)	

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BB300	Continued From page 5 ix. Signature of attending physician and nurse for all treatments and medications provided. (10-14-88) b. Emergency room records shall be filed with inpatient records when appropriate. (10-14-88) This Rule is not met as evidenced by: Based on staff interviews, record reviews, and review of hospital policies, it was determined the hospital failed to ensure the records of 8 of 32 ED patients (#'s 8, 9, 17, 19, 21, 22, 24, and #32), whose records were reviewed, documented triage assessment and reassessment information necessary to effectively identify and monitor the medical status of each patient. The findings include: Refer to A0467 as it relates to the failure to document all pertinent patient information had the potential to negatively impact patient care due to incorrect assessment and reassessment of ED patients.	BB300		